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REMARKS

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THANK YOU, MR. CHAIRMAN.

I AM PLEASED TO JOIN YOU THIS MORNING AND TO CONTRIBUTE TO THE RECORD BEING BUILT BY THIS COMMITTEE IN REGARD TO "THE FUTURE OF HEALTH CARE IN AMERICA."

I KNOW YOU'VE COVERED A GREAT MANY TOPICS IN MEDICINE AND PUBLIC HEALTH IN YOUR PREVIOUS COMMITTEE HEARINGS, AND, OF COURSE, A NUMBER OF EXCELLENT WITNESSES FOLLOW MY APPEARANCE THIS MORNING. WHAT I WOULD LIKE TO DO, THEN, IS TO TOUCH UPON THREE OVER-ARCHING ISSUES IN THIS BRIEF OPENING STATEMENT AND THEN ANSWER QUESTIONS FOR THE REMAINDER OF MY TIME.

THE FIRST ISSUE I WANT TO RAISE IS THE FUTURE RELATIONSHIP BETWEEN TECHNOLOGY AND HEALTH CARE. TECHNOLOGY HAS HAD A VERY PERVASIVE INFLUENCE SO FAR. BUT WILL IT ALWAYS BE SO?

FOR MANY YEARS WE'VE ASSUMED THAT THE HEALTH STATUS OF OUR PEOPLE WOULD CONSTANTLY IMPROVE, AS LONG AS WE CONTINUED TO PUSH AGAINST THE FRONTIERS OF BIOMEDICAL TECHNOLOGY. AND THE AMERICAN PEOPLE HAVE SUPPORTED THAT ASSUMPTION IN A WAY THAT COUNTS: THAT IS, THROUGH TAXES AND DONATIONS WILLINGLY GIVEN.

HOWEVER, IN RECENT YEARS, I'VE BEGUN TO DETECT A COUNTER-TREND, IN WHICH THE PUBLIC -- AND EVEN SOME MEMBERS OF THE MEDICAL PROFESSION ITSELF -- QUESTION THE HIGH COST AND LIMITED RESULTS OF NEW MEDICAL TECHNOLOGIES.

THERE IS, FOR EXAMPLE, A LIVELY PUBLIC DEBATE OVER THE USE OF SO-CALLED "EXTRAORDINARY" MEASURES TO SAVE OR PROLONG THE LIVES OF THE TERMINALLY ILL. I'VE BEEN INVOLVED IN THAT DEBATE FOR MANY YEARS, BOTH BEFORE AND SINCE BECOMING SURGEON GENERAL.

RECENTLY, HOWEVER, MUCH PUBLIC SENTIMENT HAS BEEN RAISED AGAINST THE USE OF SUCH MEASURES. I WOULDN'T SAY THAT MOST PEOPLE FEEL THIS WAY, BUT CERTAINLY A SUBSTANTIAL AND VOCAL MINORITY DOES NOT WANT THEIR PHYSICIANS TO PROLONG THEIR LIVES, IF THERE'S ANY CHANCE AT ALL THAT THE KIND OF LIFE BEING PROLONGED WILL BE QUALITATIVELY LESS THAN THE LIFE THEY'VE KNOWN.

IN OTHER WORDS, WHILE THE AMERICAN PEOPLE WELCOME THE EXPECTATION OF LONGER LIFE, THEY DON'T WANT LONGEVITY AT ANY COST AND THEY SEE TECHNOLOGY, IN A SENSE, "PERPETRATING" LONGEVITY UPON A DUBIOUS AND EVEN UNWILLING PUBLIC.

IN OTHER AREAS THERE IS ALSO GROWING SKEPTICISM AS TO THE ADEQUACY OF TECHNOLOGY TO SOLVE THE MAJOR CONTEMPORARY HEALTH PROBLEMS OF OUR PEOPLE. IN FACT, THE KEYSTONE OF PUBLIC HEALTH FOR THE PAST DECADE -- AND CERTAINLY FOR THE FUTURE AS WELL -- HAS BEEN THE IDEA THAT EACH PERSON MAKES THE KEY DECISIONS, DAY-BY-DAY, THAT AFFECT HIS OR HER OWN HEALTH ... DECISIONS, FOR EXAMPLE ...

* TO EAT SENSIBLY AND EXERCISE REGULARLY ...

* TO STOP SMOKING AND STOP USING DANGEROUS DRUGS ...

* TO ENSURE THAT ONE'S WORKPLACE IS SAFE AND HEALTHFUL ...

* AND TO LIVE AT HOME OR AT PLAY IN A MANNER THAT WILL ENHANCE AND NOT IMPERIL ONE'S HEALTH STATUS.

IN FACT, AS MORE AND MORE PEOPLE MAKE -- AND BENEFIT FROM -- THESE KINDS OF PERSONAL DECISIONS, I THINK WE MAY FIND THAT FEWER AND FEWER PEOPLE WILL RETAIN SUCH COMPLETE AND UNCRITICAL FAITH IN HIGH-TECH MEDICINE AS WAS THE CASE, SAY, IN THE 1950s AND 60s.

ALSO, THE NEW TECHNOLOGIES TEND TO RESPOND TO CONDITIONS THAT ARE RARE IN THE PATIENT POPULATION OR THEY REQUIRE THE KIND OF DIFFICULT ETHICAL AND MORAL CHOICES THAT MOST PEOPLE WOULD RATHER NOT MAKE.

FOR EXAMPLE, I WOULD NOT MINIMIZE THE SIGNIFICANCE OF THE ESOTERIC TECHNOLOGIES THAT REVERSE INFERTILITY. HOWEVER, THE POPULAR PREFERENCES FOR DEALING WITH THIS MEDICAL PROBLEM STILL SEEM TO BE ADOPTION, ROUTINE DRUG THERAPIES ... AND RESIGNATION.

DURING THE YEARS WHEN TECHNOLOGY WAS CONSIDERED THE SINE QUA NON OF MEDICAL PRACTICE, THE PRESSURES OF THE MARKETPLACE TENDED TO SKEW SUPPORT FOR RESEARCH AWAY FROM THE BASIC SCIENCES AND TOWARD RESEARCH APPLICATIONS AND PRODUCT DEVELOPMENT. THIS IS CLEAR FROM THE ANNUAL REPORTS OF THE NATIONAL SCIENCE FOUNDATION FOR THE PAST TWO DECADES.

BUT WHAT IF, AS I'VE INDICATED, THAT MARKET PRESSURE BEGINS TO EASE? THEN WE MIGHT SEE BASIC RESEARCH SUCCESSFULLY COMPETE FOR MORE RESOURCES: MORE BENCH SCIENTISTS, ADDITIONAL ACADEMIC FACILITIES, AND MORE GOVERNMENT AND PRIVATE FUNDS AS WELL.

CONCURRENTLY, I BELIEVE WE'LL ALSO SEE AN INCREASINGLY IMPORTANT ROLE FOR THE FIELD OF SO-CALLED "LOW-TECH" APPLICATIONS TO HEALTH CARE AND HEALTH ADMINISTRATION.

IN ONE OF HIS PLAYS, GEORGE BERNARD SHAW ASKED WHY WE PAY DOCTORS TO TAKE A LEG OFF BUT WE DON'T PAY THEM TO KEEP A LEG ON. NOW, ALMOST 80 YEARS HAVE PASSED AND WE STILL HAVEN'T COME UP WITH A GOOD ANSWER. IN FACT, OUR TECHNOLOGY-DRIVEN REIMBURSEMENT SYSTEM -- WHETHER BY GOVERNMENT OR OUT-OF-POCKET -- IS PREDICATED ON TAKING THE LEG OFF.

THAT'S TODAY. BUT I DON'T THINK THE SYSTEM WILL REMAIN THAT WAY TOMORROW BECAUSE OF THE SHIFT IN THE PUBLIC'S OWN PERCEPTION OF WHAT IT REALLY NEEDS. AND I THINK WE'RE BEGINNING TO HEAR THE PUBLIC SAY THAT IT NEEDS AND WANTS THE KIND OF HARDWARE AND SYSTEMS THAT PROMOTE HEALTHFUL LIVING OR THAT HELP OLDER PEOPLE AND PEOPLE WITH DISABILITIES OR CHRONIC ILLNESSES TO LIVE SAFELY, HEALTHFULLY, AND INDEPENDENTLY IN THEIR OWN HOMES.

I THINK WE SHOULD TRY TO UNDERSTAND HOW AND WHY THAT MAY BE HAPPENING AND WHAT IT COULD MEAN FOR THE FUTURE OF BIOMEDICAL RESEARCH AND OF HEALTH CARE IN GENERAL.

A SECOND ISSUE IS THE CHANGING RELATIONSHIP BETWEEN THE PUBLIC AND THE HEALTH CARE SYSTEM.

MANY FACTORS ARE BRINGING ABOUT THIS CHANGE. ONE IS THE INCREASED MOBILITY OF THE AMERICAN PEOPLE. THIS PHENOMENON MAKES IT LESS LIKELY THAT THE AVERAGE PATIENT WILL BE KNOWN AND SERVED BY THE SAME PHYSICIAN AND SAME HOSPITAL STAFF FOR A LIFETIME. YET, THAT HAS BEEN OUR NORM FOR ALMOST THREE CENTURIES.

ANOTHER FACTOR IS THE RISE IN PRE-PAID PRACTICES OF ONE KIND OR ANOTHER. THESE, WHILE MORE COST-EFFICIENT, ALSO TEND TO ATOMIZE PATIENT CARE. I'M NOT SAYING THE CHANGE IS GOOD OR BAD. I'M SAYING IT'S DIFFERENT AND THE DIFFERENCE IS SIGNIFICANT FOR THE LONG-TERM RELATIONSHIP BETWEEN HEALTH CARE AND THE PUBLIC.

A THIRD FACTOR IS THE WELL-ADVERTISED AND WELL-DISCUSSED SHIFT IN THE DEMOGRAPHY OF OUR COUNTRY, THE SO-CALLED "GRAYING OF AMERICA."

ALREADY THE SPECIALTY OF GERIATRICS IS RESPONDING TO NEWLY RECOGNIZED HEALTH NEEDS OF THE AGED. NOW THIS SPECIALTY JOINS TWO OTHERS -- PEDIATRICS AND FAMILY MEDICINE -- TO DIVIDE UP PRIMARY CARE AND, AGAIN, CHANGE ALL OUR TRADITIONAL IDEAS ABOUT CONTINUITY OF CARE.

I'M AFRAID THAT MANY OF THE ASSUMPTIONS UPON WHICH WE BASE MUCH OF OUR HEALTH PLANNING -- AND FINANCING, I MIGHT ADD -- MAY STILL REFLECT A PATIENT-TO-SYSTEM RELATIONSHIP THAT, FOR MANY INDIVIDUALS AND MANY INSTITUTIONS, NO LONGER EXISTS.

LET ME ILLUSTRATE THIS WITH A LITTLE ANECDOTE. LAST WINTER I CONVENED A "SURGEON GENERAL'S WORKSHOP ON SELF-HELP." MY PURPOSE WAS TO GAIN A BETTER SENSE OF WHAT WAS GOING ON IN THIS NEW AREA AND WHAT THE GOVERNMENT'S ROLE MIGHT BE -- IF ANY.

I DISCOVERED THAT AN ESTIMATED 15 MILLION AMERICANS ARE INVOLVED IN THE SELF-HELP MOVEMENT ... THAT THEY REPRESENT ALL SOCIAL, RACIAL, ETHNIC, GEOGRAPHIC, AND ECONOMIC GROUPS ... AND THAT THEY ARE FIERCELY INDEPENDENT.

I ALSO DISCOVERED THAT THEY ARE PROVIDING LEADERSHIP IN THREE HEALTH AREAS IN WHICH TRADITIONAL MEDICINE AND PUBLIC HEALTH ARE STILL SEARCHING FOR MEANINGFUL ROLES: HEALTH PROMOTION, DISEASE PREVENTION, AND THE COUNSELING FUNCTION, CALLED "COGNITIVE MEDICINE" BY SOME PHYSICIANS.

THE SELF-HELP MOVEMENT EMBRACES ALCOHOLICS ANONYMOUS AND A NUMBER OF ALLIED ORGANIZATIONS ... SMOKING CESSATION GROUPS AND PROGRAMS ... AND COUNSELING AND TREATMENT GROUPS FOR DRUG ADDICTS.

THERE'S ALSO AN EVER-EXPANDING ASSORTMENT OF "SUPPORT GROUPS" FOR PERSONS WITH FAMILY, PERSONALITY, SEXUALITY, OR INFECTIOUS DISEASE PROBLEMS; PERSONS WHO'VE JUST "KICKED A HABIT" OF SOME KIND; OR PERSONS RETURNING HOME AFTER A MAJOR HEALTH ORDEAL, SUCH AS A HEART ATTACK, CANCER TREATMENT DIAGNOSIS, A STROKE, AND SO ON.

YOU'LL NOTICE, MR. CHAIRMAN, THAT THESE DISEASES AND DISORDERS ARE ALSO AMONG THE MOST SERIOUS PUBLIC HEALTH PROBLEMS WE FACE TODAY: SUBSTANCE ABUSE, INCLUDING CIGARETTES ... THE EPIDEMICS OF SYPHILIS, HERPES, GONORRHEA, AND AIDS ... AND THE THREE PERSISTENT MAJOR KILLERS OF OUR PEOPLE: HEART DISEASE, CANCER, AND STROKE.

TRADITIONAL FEE-FOR-SERVICE MEDICINE OR TAX-SUPPORTED PUBLIC HEALTH PROGRAMS GENERALLY DO NOT RESPOND TO THIS INTENSELY PERSONAL ASPECT OF THESE PERCEIVED HEALTH PROBLEMS. ALSO, SINCE THE <u>INDIVIDUAL</u> DECIDES WHEN SUCH ASSISTANCE IS NO LONGER NEEDED, THERE IS NO GENERALLY RECOGNIZED END-POINT; THEREFORE, THERE IS NO SPECIFIC POINT AT WHICH EXPENDITURES MUST END OR REIMBURSEMENTS MUST BEGIN.

I HONESTLY MARVEL AT THE EXTRAORDINARY DEGREE TO WHICH AVERAGE AMERICANS ARE ENGAGED IN THESE "DO-IT-YOURSELF" HEALTH PROGRAMS AND ALSO THE DEGREE TO WHICH THEY ARE TRULY HELPED BY THEM.

MY ONLY CONCERN -- AND IT'S A MAJOR CONCERN -- IS THAT SOME PEOPLE WHO NEED THE HELP OF EXPERTS WITH MEDICAL TRAINING AREN'T GETTING IT OR ARE AVOIDING IT ... AND THEIR HEALTH AND POSSIBLY THEIR LIVES MAY BE IN PERIL AS A CONSEQUENCE.

I'D LIKE TO SEE MORE PHYSICIANS, NURSES, AND ALLIED HEALTH PROFESSIONALS BECOME INVOLVED IN WHAT IS NOW CALLED "SELF-HELP" OR "DO-IT-YOURSELF" HEALTH CARE. MY INSTINCTS TELL ME IT WOULD BE VERY USEFUL IF THEY DID.

BUT WHETHER TRADITIONAL MEDICINE AND PUBLIC HEALTH DO OR DO NOT GET INVOLVED, I BELIEVE THIS MOVEMENT WILL CONTINUE TO GROW AND BECOME NOT MERELY AN "ALTERNATIVE" SYSTEM OF HEALTH CARE BUT IN FACT OUR OTHER NATIONAL SYSTEM OF HEALTH MAINTENANCE, HEALTH PROMOTION, AND DISEASE AND DISABILITY PREVENTION.

AND THAT LEADS ME TO THE THIRD AND FINAL ISSUE I WANT TO TOUCH ON THIS MORNING, MR. CHAIRMAN. IT IS THE RELATED ISSUE OF HEALTH, COMMUNITY VALUES, AND PUBLIC SUPPORT.

I MENTION IT BECAUSE, IN THE COURSE OF MY INVOLVEMENT WITH THE AIDS EPIDEMIC, I'VE SEEN THE OUTLINES OF THIS ISSUE ALREADY FORMING. ALSO, IT IS A KIND OF COROLLARY OF THE ISSUES I'VE DISCUSSED SO FAR.

LET ME BEGIN BY SAYING THAT THE AMERICAN PEOPLE ARE GENEROUS TO A FAULT. THROUGH TAXES AND THROUGH PERSONAL, OUT-OF-POCKET DONATIONS THEY WANT TO HELP EVERYONE IN OUR SOCIETY ACHIEVE GOOD HEALTH AND THE GOOD LIFE THAT COMES WITH GOOD HEALTH.

BUT THEY CAN ALSO BECOME IMPATIENT. FOR EXAMPLE, MOST AMERICANS DISAPPROVE OF SMOKING AND WOULD LIKE TO SEE ALL SMOKERS STOP. AND, THROUGH THE SELF-HELP MOVEMENT, MANY SMOKERS ARE INDEED QUITTING THE HABIT. BUT IT'S HAPPENING VERY SLOWLY.

HENCE, THE NON-SMOKING PUBLIC IS ASKING FOR NEW AND STRONGER STATE AND LOCAL LAWS TO CURB CIGARETTE SMOKING IN THE WORKPLACE AND IN ALL PUBLIC GOVERNMENTAL AND COMMERCIAL BUILDINGS.

MOST HEALTH AND LIFE INSURANCE COMPANIES NOW HAVE A SEPARATE -- AND HIGHER -- PREMIUM FOR SMOKERS, ALSO, ON THE THEORY THAT A PERSON WHO SMOKES OUGHT TO PAY A LARGER SHARE FOR THE CONSEQUENCES OF THAT UNHEALTHY BEHAVIOR.

NEW LAWS, HIGHER PREMIUMS, AND SEGREGATION AT THE WORKSITE ARE EXAMPLES OF PUBLIC RETRIBUTION DIRECTED AGAINST SMOKERS. BUT IT IS BEING EXERCISED AGAINST OTHERS AS WELL: DRUNK DRIVERS, DRUG ADDICTS, PROMISCUOUS AND PREGNANT TEEN-AGERS, AND OTHERS WHO ARE PERCEIVED AS DEVIATING FROM THE COMMUNITY'S STANDARD OF NORMATIVE BEHAVIOR.

BUT THE AMERICAN PEOPLE ARE STILL VERY GENEROUS AND VERY FORGIVING. THEY DO HONESTLY BELIEVE IN -- AND WILL CONTINUE TO SUPPORT -- PUBLIC HEALTH PROGRAMS THAT PROMISE REDEMPTION.

BUT THEY AREN'T PUSH-OVERS. AND IT'S POSSIBLE THAT THE AMERICAN PEOPLE -- ALREADY TRAVELING THE ROAD OF RETRIBUTION -- MAY BEGIN TO EXERCISE THEIR RETRIBUTIVE POWERS MORE AND MORE.

THE OBJECT WILL CONTINUE TO BE THE INDIVIDUAL WHO WILFULLY BEHAVES IN A HIGH-RISK MANNER: DRUNKS, DRUG ADDICTS, CIGARETTE SMOKERS, SEXUALLY PROMISCUOUS PEOPLE OF ALL AGES, DANGEROUS DRIVERS, CHILD BEATERS, AND OTHERS.

AND AT THE TOP OF THAT LIST RIGHT NOW IS THE PERSON WITH AIDS ... SOMEONE WHO CONTRACTED THAT LINGERING BUT FATAL DISEASE THROUGH WHAT THE COMMUNITY REGARDS AS AN UNSAVORY ACT: SODOMY OR INTRAVENOUS DRUG ABUSE.

IT'S POSSIBLE THAT A PUBLIC REACTION OF RETRIBUTION TOWARD PEOPLE WITH AIDS MAY COME ABOUT IN THE 1990s, WHEN THE ANNUAL COSTS OF AIDS-RELATED RESEARCH AND PATIENT CARE ARE EXPECTED TO REACH OR EXCEED $5 BILLION.

THE 1990s IS ALSO WHEN NEW CASES OF AIDS WILL BE REPORTED AMONG PEOPLE WHO MOST LIKELY BECAME INFECTED SOMETIME AFTER -- AND MAYBE LONG AFTER -- THE HUMAN IMMUNODEFICIENCY VIRUS, OR H.I.V., WAS IDENTIFIED AND THE NATIONWIDE AIDS EDUCATION PROGRAM WAS WELL UNDER WAY.

SUCH A PUBLIC RESPONSE WOULD BE A TRAGIC DEVELOPMENT -- BUT NOT UNEXPECTED. IT WOULD BE CONSISTENT WITH THE OTHER RETRIBUTIVE TRENDS I MENTIONED EARLIER.

OUR CHALLENGE, THEN, WOULD BE TO RECOGNIZE -- IF AND WHEN IT COMES -- THIS REACTION BY THE GENERAL PUBLIC AGAINST HIGH-RISK INDIVIDUALS AND TO TRY TO CHANNEL IT INTO MORE POSITIVE, MORE TOLERANT RESPONSES.

AT STAKE IS THE VERY BASIS OF THE AMERICAN APPROACH TO PUBLIC HEALTH ITSELF: THAT IS, THE MAJORITY OF THE AMERICAN PEOPLE WHO LIVE THEIR LIVES IN A GENERALLY HEALTHFUL, LOW-RISK MANNER HAVE BEEN WILLING TO SUPPORT -- SOMETIMES WILLINGLY AND SOMETIMES GRUDGINGLY -- THE SERVICES THAT TAKE CARE OF A MINORITY OF PEOPLE WHO LIVE IN A GENERALLY UNHEALTHFUL, HIGH-RISK MANNER.

IN MANY RESPECTS, THIS IS THE MOST IMPORTANT ISSUE OF ALL. WE KNOW THAT HEALTH COSTS ARE TAKING A LARGER AND LARGER SHARE OF THE GROSS NATIONAL PRODUCT. IT STANDS TO REASON, THEN, THAT MORE AND MORE AMERICANS WILL BEGIN TO LOOK WITH GREATER CRITICAL INTEREST NOT ONLY AT OUR SYSTEM OF HEALTH CARE BUT ALSO AT THE PEOPLE DIRECTLY BENEFITING FROM THAT SYSTEM.

THAT WOULD BE A VERY WELCOME DEVELOPMENT BECAUSE IT IS ROOTED IN OUR SYSTEM OF PARTICIPATORY DEMOCRACY. BUT IT CAN BE A PAINFUL DEVELOPMENT FOR MANY OF OUR CITIZENS, AND WE OUGHT TO BE PREPARED FOR THAT.

LET ME CLOSE, THEN, BY SAYING THAT I ANTICIPATE CERTAIN MAJOR CHANGES IN AMERICAN HEALTH CARE OVER THE NEXT SEVERAL DECADES. SOME WILL BE EASIER TO EXPERIENCE THAN OTHERS. BUT, ON BALANCE, I SEE THEM AS CONTRIBUTING TO A STRONGER, MORE RESPONSIVE, MORE CONTEMPORARY SYSTEM OF HEALTH CARE FOR THE NEXT AND FOR SUCCEEDING GENERATIONS OF AMERICANS.

THANK YOU. AND NOW, IF YOU WISH, I'D BE PLEASED TO ANSWER QUESTIONS.

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